



The Carolinas Center *for* Medical Excellence

**CCME PCS Provider training session 8**

**June 2008**

**Registration form**

Location requested: \_\_\_\_\_ Location Date: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Position: \_\_\_\_\_

Organization: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_, NC Zip: \_\_\_\_\_

County: \_\_\_\_\_

UPIN/Provider #: \_\_\_\_\_

Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

Fax #: \_\_\_\_\_

Email: \_\_\_\_\_

Referred by/How did you hear about this event?

\_\_\_\_\_  
\_\_\_\_\_

May we send you e-mail updates on new information, features, and tools on the CCME web site?

please check: ☐ Yes ☐ No

**Please fax completed form to the attention of  
Alisha Brister at 919-380-9457**